

***Frequently Asked Questions from Hospice Workshops
Conducted Nov. 14-16, 2005***

1. If you admit a patient with a chronic illness that meets the Medicaid Hospice criteria initially but then stabilizes at what point should you discharge them from the hospice program? (i.e.: end of benefit period or end of six months?) **At the point that the hospice provider determines the patient is chronic stable the provider should set in motion a process to discharge the patient.**
2. If a patient is Medicaid room and board and they have a hospitalization of 3 days or more and return to the nursing home on Medicare skilled days but the family wants hospice care can the family waive skilled and continue Medicaid room and board? **Depends on the circumstances. However since Medicare is likely the payer for the Hospice care, this would be a question for Medicare. (There is a C.F.R. reference that speaks to “Refusal of certain transfers.” This reference states “An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate—(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (2) A resident’s exercise of the right to refuse transfer under paragraph (o) (1) of this section does not affect the individual’s eligibility or entitlement to Medicare or Medicaid benefits.”**
3. What can be done about Hospice programs that incorrectly market hospice criteria and services? **Complaints/comments are heard from doctors’ offices, from family members and patients of organizations in question. There are several courses of action which can be taken. The person or organization noting such an activity can report this to the Agency and/or Hospice Association. Further action could include referral of physicians identified to the Board of Medical Examiners for unethical behavior; intentionally or knowingly certifying a patient for hospice services without evidence of terminality and referral of the hospice agency to the licensure board.**
4. What if an HIV patient wants to continue protease inhibitors and hospice doesn’t provide it-do they still qualify if they meet all of the other criteria? **No, not if the patient is being admitted to hospice with this as the hospice diagnosis. Protease inhibitors would be considered to “significantly prolong life” and therefore is not consistent with palliative care which seeks to neither hasten nor prolong life.**
5. How can a Hospice provider continue to admit patients when the patients are clearly not end stage and/or terminal? **A hospice provider should not continue to admit patients when the patients are not end stage and/or terminal. Hospice care as defined by the National Hospice and Palliative Care Organization is “Hospice (care)=Support and care for persons in the last**

phase of incurable disease so that they may live as fully and comfortably as possible.”

6. What happens to the fund that was allocated for the year if a waiver recipient dies before the year is up (because the slot can not be filled before the year is up)?
Funds for waiver services are not allocated for a specific individual. If an individual receiving waiver services dies during the waiver year, the funds are used within the waiver program as needed.
7. If a patient has an illness that is not listed on the criteria; and patient has several co-morbidity diseases what would be the appropriate diagnosis? **The provider should list the diagnosis that is the cause of terminality as the hospice and primary diagnosis. All other diagnoses can be provided as secondary diagnoses.**
8. If a patient has “advanced cancer” and declines further workups to establish location or level of metastatic disease:
 - a) Will they be denied hospice?
 - b) Will patient be forced to undergo a work up?
 - c) If “b” is yes, will it not cost more?**An applicant for waiver services will not be forced to undergo a work up. However, the applicant should be made aware of the Medicaid requirements for certification to the Hospice Program and that there refusal of certain test may deem them ineligible for the Hospice benefit if a definitive diagnosis of terminal illness cannot be determined.**
9. If a patient is evaluated for hospice under Medicaid and the Hospice feels they are appropriate but lack a piece of documentation, can they admit the patient and not bill Medicaid until the documentation is verified and then billed from the point of meeting all Medicaid criteria? **Yes.**
10. Is there any scientific evidence to back up the criteria Medicaid has listed for terminal diagnoses? This question is asked because a study done with the LMRP’s says you can flip a coin and get same results for proof of terminality.
The Alabama Medicaid Agency utilized the Medicare LMRP’s as stepping stones or the beginning of the process. In addition, criteria from other states and entities, evidenced-based guidelines and peer-reviewed clinical literature were utilized to determine what factors or criterion were prognostic indicators.
11. Can a patient be discharged from hospice for consistent noncompliance? **Yes. However, the documentation should clearly note the reason for the discharge and specific examples of non-compliance. The Hospice participant should be educated on the purpose of the Hospice Program and that non-compliance may result in discharge from the program.**

12. Can a patient have four periods of elections during their lifetime? **Apparently there has been some confusion about whether there are “four” election periods. The Administrative Code Rule No. 560-X-51.02 (4) is being revised and will not include the language “four periods of elections”. The proposed language defines an election period as a “predetermined timeframe...” and gives examples of those timeframes.**
13. If Medicaid primary payer patient enters the hospice for a diagnosis clearly not related to the terminal diagnosis, why is it necessary for hospice to discharge the patient? **The decision to discharge a Medicaid primary payer patient entering the hospice program for a diagnosis clearly not related to the terminal illness is the providers call as whether to continue care or discharge the patient. However, if care is provided to this patient and the admission is not related to the terminal diagnosis, the Medicaid Agency will not provide reimbursement to the hospice provider.**
14. Are there plans to make exceptions for hospice patients who reside in a nursing home less than 30 days for Medicaid room/board payment/reimbursement because they are “hospice” and terminal? **No, not at this time. The 30 day institutional rule is a federal Medicaid rule.**
15. How does “open access” fit into the Medicaid? (There is a push to allow access for pain control, some chemotherapy, etc for palliative care, relief of pain and symptoms for short term. Medicare and Medicaid require patient prognosis of limited life expectancy of six months or less. If this is met then it is okay to admit even if chemotherapy continues as long as chemo is for relief of symptoms not aimed at or likely to cure or significantly prolong life.) **Palliative Care is comfort care with the primary goal of providing relief from pain and suffering. As long as the goal is this then a person can receive chemotherapy and still qualify for hospice care. Example: A person with lung cancer may be given chemotherapy to reduce the size of the tumor to lessen respiratory distress symptoms. The cancer has already metastasized and the medication will not change the prognosis.**
16. When you have a patient at home with Medicare and they move into the nursing home and apply for Medicaid how do we fill out the Form 165 (effective date)? **When the patient enters the nursing home the effective date on the Form 165 should be the date the individual enters the nursing home. This date has no impact on the hospice election date the individual had in the community. Is it the date of hospice admission or date the Medicaid becomes effective? The date on the 165 is the date Medicaid began paying the room and board.**
17. Could you elaborate on eligibility of fast level greater than or equal to 7 on the Alzheimer’s requirements? **This simply means that all of the sub-stages in 7 must be met. This will be corrected to say “equal to 7”.**

18. With HIV medications what constitutes palliation verses aggressive treatment?
Patients with a hospice diagnosis of HIV/Aids can be on medications for prophylaxis and treatment of infections but cannot be on protease inhibitors which are considered aggressive treatment and not palliative since they can “significantly prolong life.”
19. With ALS how does the ventilation or artificial feeding impede the hospice referral? What more would be indicated to admit while on the vent or artificial feeding? **A patient can receive enteral feedings and still qualify for hospice with an ALS or similar diagnosis if the enteral feeding still results in insufficient calories and fluids to sustain life. Adult patients must refuse ventilatory support to qualify since this support can be expected to “significantly prolong life.” Pediatric patients may have ventilatory support and/or enteral feedings and still qualify for hospice program services.**
20. What steps should a provider take if an individual meets hospice criteria and is ready for admission but financial is pending through the Medicaid District Office? **The provider should get the Form 165 completed for the applicant. Once the financial eligibility is awarded, the individual may be added to the Long Term Care file.**
21. If a straight Medicaid recipient in the community transitions into the nursing home, is a new election form required? **Yes, a new election form is required. The election form alerts the agency that the recipient is entering the facility on the hospice program so the appropriate reimbursement rate is paid to the nursing home. *Policy changes are being implemented that will impact this procedure.***
22. A recipient in the nursing home elects Medicare (Part A) Hospice. Would AMA need an election form even though Medicaid is only paying for the room and board? **Yes, the Medicaid Election Form 165 must be completed. What about for subsequent election periods? No, we would only need notification if the recipient no longer receives hospice and returns to LTC nursing home care. *Policy changes are being implemented that will impact this procedure.***